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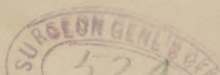
**A CASE OF GASTROPTOSIS AND MERYCISMUS,  
WITH VOLUNTARY DISLOCATION OF THE  
STOMACH AND KIDNEY.<sup>1</sup>**

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THE case that I have the honor of presenting to you this evening is unique in many respects, and I have been unable to find anything like it in medical literature. The young man is twenty years of age. In June, 1892, he fell on his right scapula, without any appreciable sequences. About eight months after the accident, in consequence of confinement incident to his occupation as a chemist, he began to suffer from neurasthenic symptoms, which had become intensified at the time he was referred to me by Dr. Jones, of this city. I have never regarded neurasthenia as a pathologic entity, but as a symptom of varied pathologic conditions; and I can say, without exaggeration, that I have never yet examined a case of so-called neurasthenia without discovering some distinct morbid condition which, when removed, cured the affection. The diagnosis of neurasthenia is a mistake in diagnosis. It is a conclusion based on subjective symptomatology. Subjective symptoms should only be employed as accessory evidence in our objective examinations.

This patient's chief complaint is and has been the

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rapid accumulation of gas in the stomach, and in his efforts to expel the gas he has developed unusual control over the diaphragm, to which I attribute some of the visceral phenomena that I shall presently show you. In general the patient suffers from nervous dyspepsia, prolapse of the transverse colon, stomach, and right kidney, a symptom-complex described by Glenard as *enteroptosis*, a term which in our case may be substituted by a better one, viz., *splanchnoptosis*. The prolapse of the abdominal viscera in this case is acquired, and may be attributed to a mechanical origin, superinduced by repeated voluntary diaphragmatic contractions of the abdominal viscera. The apex-beat of the heart can be felt in the fifth intercostal space within the mammary line, but by diaphragmatic action the patient can cause it to descend to the seventh intercostal space, a condition, if I may so call it, of *voluntary cardioptosis*. You will observe when I ask him to dislocate his right kidney, the latter can be distinctly seen and felt as it bulges in a limited area of the right hypochondriac region in the mammary line. The kidney recedes on suspension of diaphragmatic action. That the kidney resumes its normal place is evidenced by the distinct change in the percussion-note in the right lumbar region. I will now introduce the soft rubber stomach-tube, but before it enters the stomach I wish to direct your attention to a method of intra-thoracic auscultation recently described by Richardson. If I connect the terminal of my stethoscope with the stomach-tube, with the end of the latter distant about ten inches from the incisor teeth I hear the two sounds of the heart with unusual distinctness. I direct attention to this method of auscultation because I believe that, while its use will always be limited, it will prove of signal value when ordinary auscultation is unsatisfactory. In this case I thought a murmur was present, but suspicion was dispelled by intra-thoracic auscultation. I believe the latter form of auscultation

to subserve another, to my knowledge, hitherto undescribed purpose in percussion of the stomach. In the employment of the gastroduaphane the clinician is forced to admit the uncertainty of conventional methods in determining the area of the stomach. This I attribute to the fact that when percussion is attempted over the stomach, especially in pathologic cases, the transmitted percussion-blow causes the stomach to contract, and in place of dulness one obtains a tympanitic sound. Now, with the rubber tube in the stomach connected with the stethoscope, as in Richardson's method of auscultation, percussion conducted over the entire area of the stomach yields a clear metallic percussion sound. This method of intra-gastric auscultation is worthy of development.

I will now introduce the gastroduaphane. You will observe that I direct the patient to bring his chin forward on his chest. This maneuver greatly facilitates the introduction of the tube by bringing the esophagus in a direct line with the throat. You can now see the illuminated area. By shifting the lamp I can trace the stomach nearly to the cardiac orifice. Illumination shows the stomach to be prolapsed (*gastroptosis*) and only slightly dilated. You can also see with what ease the patient shifts his stomach about; to the right, left, upward, and downward. The greatest voluntary dislocation is upward. He first dislocates the stomach downward to a point on a level with the crests of the ilia, then, by a supreme effort, he draws his stomach upward until it can no longer be seen. When the patient practises rumination he throws his stomach into a vertical position, which you can easily see. The phenomenon here noted may explain some cases of merycismus and food-regurgitation. A feature readily observed in this case is *peristaltic unrest* of the stomach. I will produce it by percussing the stomach-region. You note that the muscular waves diminish the extent of the illuminated area.

The patient can also develop a *phantom-tumor*. This he does by buccal insufflation of the stomach, and by relaxing his recti muscles and forcibly contracting his diaphragm; at the same time he arches the vertebral column forward.

As a concluding phenomenon the patient will demonstrate his ability to compress the aorta to obliteration, causing a disappearance of the femoral pulse. This phenomenon I likewise attribute to contraction of the diaphragm at a point where the artery passes through the muscle.